MEDICAL AUTHORIZATION

I hereby authorize any treating physician, hospital, or medical or medically related facility, United HealthCare of Ohio, any employer, the Social Security Administration, and the Internal Revenue Service to furnish Massachusetts Casualty and/or Disability Management Services with information regarding my medical history and/or work record and income so that benefits can be determined. This information shall be solely for purposes of Mass Casualty/Disability Management Services. Absent a court order, the information obtained as a result of this authorization may not then be shared with any third party. All previous authorizations signed by me are hereby revoked. This authorization is valid for ninety (90) days from the date of the most recently executed Continuation of Disability form. A photocopy of this form shall be valid as an original.

Dated: 21 July 2000

Eric Jeffries